

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

1598

County DorchesterVillage or City Vienna (No. —, St.; Ward)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 112.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

(Still Born) Adams. (6 months foetus)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single.  
(Write the word)

## 6 DATE OF BIRTH

Feb. 11, 1914  
(Month) (Day) (Year)

## 7 AGE

6 months fetus If LESS than 1 day, hrs. — min. ?  
0 yrs. 0 mos. 0 ds. OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work —(b) General nature of industry, business, or establishment in which employed (or employer) —9 BIRTHPLACE  
(State or country)Maryland, U.S.A.

## PARENTS

## 10 NAME OF FATHER

Lachius D. Adams11 BIRTHPLACE OF FATHER  
(State or country)Maryland

## 12 MAIDEN NAME OF MOTHER

Rebecca R. Bradley13 BIRTHPLACE OF MOTHER  
(State or country)Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. D. Adams, Father(Address) Vienna, Md.

## 16

Filed FEB 12 1914 Edward E. Landon  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH about Feb. 9, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from —, 191, to —, 191,

that I last saw him alive on Still Born, 191.and that death occurred on the date stated above, at — m.

The CAUSE OF DEATH\* was as follows:

Miscarriage(Duration) — yrs. — mos. — ds.Contributory  
Secondary —(Duration) — yrs. — mos. — ds.(Signed) E. E. Landon, M. D.2-11-, 1914 (Address) Vienna, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence —

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

No formal Burial.—, 191.

## 20 UNDERTAKER

## ADDRESS

None required.

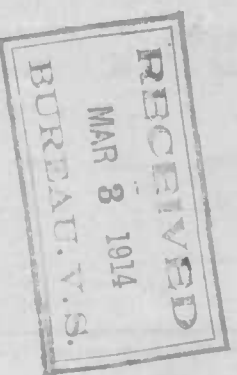
# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

1599

STATE OF MARYLAND  
CERTIFICATE OF DEATH

County

Dorchester

Registration Dist. No. 110

Village or City

Petersburg

(No. \_\_\_\_\_)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Eunice Aldridge

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Nov 12, 1912  
(Month) (Day) (Year)

7 AGE

2 yrs. 2 mos. 17 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Dorchester Co Md

PARENTS

10 NAME OF FATHER

Josiah Aldridge

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Cora Cephus

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Cora Aldridge

(Address)

Hunlocks Md

15

Filed

Feb 17, 1914 Robert L Hastings

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

2 17, 1914  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

1/25, 1914, to 2/15, 1914, that I last saw him alive on 2/15, 1914

and that death occurred on the date stated above, at 10:20 a.m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis

(Duration) yrs. 1 mos. ds.

Contributory  
Secondary

none

(Duration) yrs. mos. ds.

(Signed)

G. Rogers Myers

M. D.

2/17, 1914 (Address) Hunlocks Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. to the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Petersburg Md

Feb 18, 1914

20 UNDERTAKER

ADDRESS

H. A. McIlwain &amp; Co. Hunlocks

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

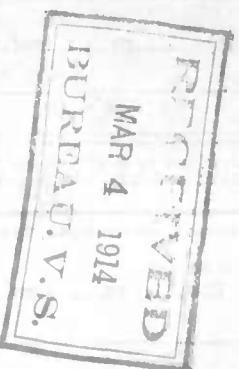
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death.**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1 PLACE OF DEATH<br>County <u>Dorchester</u>   |  | 1600   |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH |  |
| Village or City <u>Cambridge</u> (No. <u>104</u> )   |  | St. <u>Dorchester</u>  |  | Registration Dist. No. <u>116</u>         |  |
| 2 FULL NAME <u>Minnie Anderson</u>   |  |  |  |   |  |
| PERSONAL AND STATISTICAL PARTICULARS   |  |  |  |   |  |
| 3 SEX<br><u>Female</u>   | 4 COLOR OR RACE<br><u>colored</u>                        | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br><u>Single</u><br>(Write the word) |  |   |  |
| 6 DATE OF BIRTH<br><u>Nov. 10</u> , 191 <u>2</u><br>(Month) (Day) (Year)   |  |  |  |   |  |
| 7 AGE<br><u>1</u> yrs. <u>4</u> mos. <u>17</u> ds. If LESS than 1 day, ____ hrs. OR ____ min. ?  |  |  |  |   |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work. <u>at home</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) <u>none</u>  |  |  |  |   |  |
| 9 BIRTHPLACE<br>(State or country) <u>Ind</u>  |  |  |  |   |  |
| PARENTS  | 10 NAME OF FATHER <u>Wm. Anderson</u>                    |  |  |   |  |
|  | 11 BIRTHPLACE OF FATHER<br>(State or country) <u>Ind</u> |  |  |   |  |
|  | 12 MAIDEN NAME OF MOTHER <u>Maggie Collins</u>           |  |  |   |  |
| 13 BIRTHPLACE OF MOTHER<br>(State or country) <u>Ind</u>   |  |  |  |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Maggie Anderson</u><br>(Address) <u>Salmon Dr. City</u>   |  |  |  |   |  |
| 15 Filed <u>Feb. 27</u> , 191 <u>4</u> <u>E. E. Wolff</u> REGISTRAR  |  |  |  |   |  |
| MEDICAL CERTIFICATE OF DEATH   |  |  |  |   |  |
| 16 DATE OF DEATH <u>Feb. 27</u> , 191 <u>4</u><br>(Month) (Day) (Year)   |  |  |  |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Feb. 22</u> , 191 <u>4</u> , to <u>Feb. 27</u> , 191 <u>4</u> , that I last saw her alive on <u>Feb. 26</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>1 P.</u> m.<br>The CAUSE OF DEATH* was as follows:<br><u>Enterocolitis</u><br>(Duration) ____ yrs. ____ mos. <u>14</u> ds.<br>Contributory<br>Secondary<br>(Signed) <u>E. E. Wolff</u> , M. D.<br><u>Feb. 27</u> , 191 <u>4</u> (Address) <u>Cambridge, Ind</u> |  |  |  |   |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  |  |  |  |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.<br>Where was disease contracted, If not at place of death? ____<br>Former or usual residence ____  |  |  |  |   |  |
| 19 PLACE OF BURIAL OR REMOVAL<br><u>Airey, Ind.</u>  |  |  |  |   | DATE OF BURIAL<br><u>Mar. 1</u> , 191 <u>4</u> |
| 20 UNDERTAKER<br><u>Turner &amp; Co. City</u>  |  |  |  |   | ADDRESS  |



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

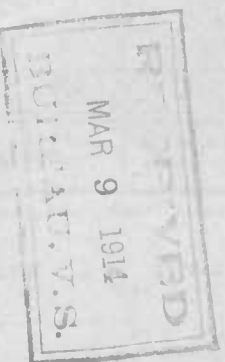
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1 PLACE OF DEATH 1601

County

Dorchester

Village or City

Wrights

(No.

St.

Ward)

Registration Dist. No.

117

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mary A. Belle

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

widow

6 DATE OF BIRTH

Mar 10, 1837

(Month)

(Day)

(Year)

7 AGE

76 yrs. 11 mos. 14 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md

## PARENTS

10 NAME OF FATHER

Harper

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

no information

13 BIRTHPLACE OF MOTHER

(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Same. Belle

(Address)

Cambridge

15

Filed

Feb 24, 1914 S. A. Stokes

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb

24

, 1914

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1914, to Feb 24, 1914,

that I last saw him alive on Feb 24, 1914,

and that death occurred on the date stated above, at 10 a. m.

The CAUSE OF DEATH\* was as follows:

Broncho-pneumonia

(Duration) yrs. mos. 6 ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed)

S. A. Stokes

Feb 24, 1914 (Address) Cameronsville, M. D.

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Cameronsville

DATE OF BURIAL

Feb 26, 1914

20 UNDERTAKER

Kills &amp; Bro

ADDRESS

Cambridge

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

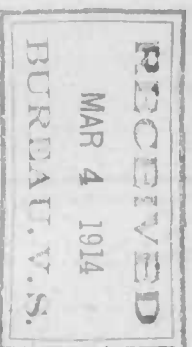
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*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or concurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Brookview 1602

Village or City

Brookview (No. ....)

St.; Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 112.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Lloyd Brinsfield

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

February 12<sup>th</sup>, 1906  
(Month) (Day) (Year)

7 AGE

8

yrs.

0

mos.

16

ds.

If LESS than  
1 day, .... hrs.  
OR .... min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Linwood Denhard Brinsfield

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Lillian Madona Marine

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph E. Bell (Neighbor)

(Address)

Vienna, R. F. D. #1, Ind.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb. 28

1914

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, that I attended deceased from

Feb. 22<sup>nd</sup>, 1914, to Feb. 28<sup>th</sup>, 1914.

that I last saw him alive on Feb. 28, 1914

and that death occurred on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH\* was as follows:

Measles (Duration) .... yrs. .... mos. 9 ds.

Contributory  
Secondary

Bronchitis (Duration) .... yrs. .... mos. 7 ds.

(Signed) J. E. Maguire, M. D.

Witness, 1914. (Address) Vienna

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brookview, Maryland March 2, 1914

20 UNDERTAKER

ADDRESS

Jerome J. Frampton Federalsburg, Md.

FEB 28 1914

S. S. Lamkin

Deputy Local REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

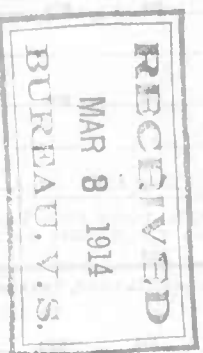
Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the misase causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the misase causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

1603

County

Dorchester

Village or City

Lloyds

(No.

St.

Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Eli Cephias

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Negro

5 SINGLE,  
MARRIED,  
WIDOWED,  
ORDIVORCED  
(Write the word)

unmarried

## 6 DATE OF BIRTH

July

(Month)

7

(Day)

1897

(Year)

## 7 AGE

56

yrs.

6

mos.

18

ds.

If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Farm laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE

(State or country)

Md

## PARENTS

## 10 NAME OF FATHER

Eli Cephias

## 11 BIRTHPLACE OF FATHER

(State or country)

Md

## 12 MAIDEN NAME OF MOTHER

Elizabeth Morris

## 13 BIRTHPLACE OF MOTHER

(State or country)

Md

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. W. Mortimer

(Address)

Carnersville

## 15

Filed

Mar 1

1914

S. A. Stokes

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Feb

28

1914

(Month)

(Day)

(Year)

## 17

I HEREBY CERTIFY, That I attended deceased from

Feb 27

1914

to Feb 27

1914

that I last saw him alive on Feb 27, 1914

and that death occurred on the date stated above, at 11 P m.

The CAUSE OF DEATH\* was as follows:

Heart disease

(Duration) yrs. mos. ds.

## Contributory

Secondary

recurrently. Euphras -

tasis

(Duration) yrs. mos. ds.

(Signed)

S. A. Stokes

M. D.

Mar 1, 1914 (Address) Carnersville

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs. mos. ds.

In the

State

yrs. mos. ds.

Where was disease contracted,  
if not at place of death?

Former or

usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Carnersville

## DATE OF BURIAL

Mar 2, 1914

## 20 UNDERTAKER

Le Compte &amp; Harper

## ADDRESS

Cambridge

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercles of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 1604

County DorchesterVillage or City Fishing Creek (No. 189)

St.; Ward

Registration Dist. No. 115

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME George E. Creighton

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH November 25<sup>th</sup>, 1834  
(Month) (Day) (Year)

7 AGE 79 yrs. 2 mos. 23 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Oysterman  
(b) General nature of industry, business, or establishment in which employed (or employer) Oysterman

9 BIRTHPLACE (State or country) Dorchester Co., Md.

10 NAME OF FATHER Samuel M. Creighton

11 BIRTHPLACE OF FATHER (State or country) Dorchester Co., Md.

12 MAIDEN NAME OF MOTHER Letitia Travers

13 BIRTHPLACE OF MOTHER (State or country) Dorchester Co., Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. R. Breighton(Address) Fishing Creek, Md.

15 Filed Feb. 18<sup>th</sup>, 1914 T. H. Houston  
Local REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February 17<sup>th</sup>, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, and

The CAUSE OF DEATH\* was as follows:

unknown, but from  
natural causes

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Frederick Tyler acting coronor

Feb. 17, 1914 (Address) Fishing Creek

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Fishing Creek Church-yard DATE OF BURIAL Feb. 18<sup>th</sup>, 1914

20 UNDERTAKER

W. H. Simmons & Co. ADDRESS Fishing Creek, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

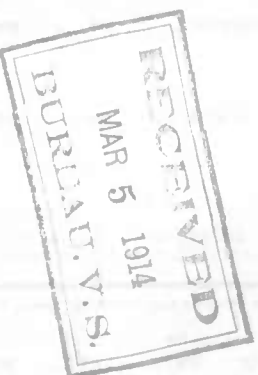
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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PLACE OF DEATH

1605

County

Dorchester

Village or City

East New Market

(No.)

St;

Ward)

Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME

Aaron A. Daskields

## PERSONAL AND STATISTICAL PARTICULARS

SEX

male

COLOR OR RACE

Colored

SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

married

DATE OF BIRTH

May 22, 1888

(Month)

(Day)

(Year)

AGE

55 yrs. 8 mos. 24 ds.

If LESS than 1 day, hrs. OR min. ?

OCCUPATION

(a) Trade, profession, or particular kind of work.

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

Farming

BIRTHPLACE (State or country)

Md

NAME OF FATHER

Aaron Daskields

BIRTHPLACE OF FATHER (State or country)

Md

MAIDEN NAME OF MOTHER

Rachel Hopkins

BIRTHPLACE OF MOTHER (State or country)

Del.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Daskields

(Address)

East New Market Md

15

Filed

191

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Feb 16, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Feb 14, 1914, to Feb 16, 1914

that I last saw him alive on Feb 16, 1914

and that death occurred on the date stated above, at 7 P. m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis of Lung

(Duration)

unknown

yrs.

mos.

ds.

Contributory (Secondary)

unknown

(Duration)

yrs.

mos.

ds.

(Signed)

Edward J. Jones

M. D.

Feb 17, 1914

(Address)

East New Market Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

E. N. Market Md.

DATE OF BURIAL

2/19, 1914

20 UNDERTAKER

H. H. Wiloughby

ADDRESS

E. N. Market

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

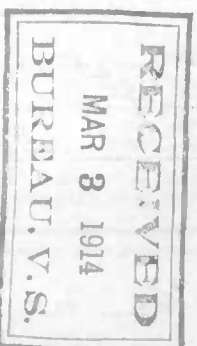
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

1606

County

Dorchester

Village or City

Grapo

(No.

Registration Dist. No.

114

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Ada Foster

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

Colored

5 SINGLE,  
MARRIED,  
WIDOWED,  
ORDIVORCED  
(Write the word)

6 DATE OF BIRTH

Jan 5, 1914

7 AGE

1 yrs. 1 mos. 1 ds. OR 1 day, 1 hrs. 1 min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Dorchester

PARENTS

10 NAME OF FATHER

Bangston Ennalls

11 BIRTHPLACE OF FATHER

(State or country)

Dorchester

12 MAIDEN NAME OF MOTHER

Lillie Foster

13 BIRTHPLACE OF MOTHER

(State or country)

Dorchester

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Johnson

(Address)

Craze

15

Filed

Feb 7, 1914 W. J. Laurick

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb 6, 1914

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

1914, to 1914,

that I last saw him alive on 1914

and that death occurred on the date stated above, at 29 hrs. m.

The CAUSE OF DEATH\* was as follows:

Convulsions of fits

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

W. J. Laurick, M. D.

Feb 6, 1914 (Address) Lakeside

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fosters Burying ground Feb 7, 1914

20 UNDERTAKER

ADDRESS

A. J. Kirwan Grapo

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

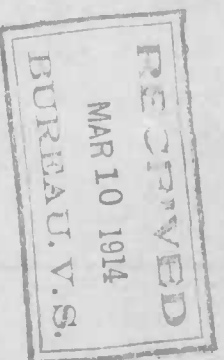
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## 1 PLACE OF DEATH

County

Village or City

## 2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

male

## 4 COLOR OR RACE

White

## 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

## 6 DATE OF BIRTH

Feb 13

(Month)

(Day)

1914  
(Year)

## 7 AGE

Infant

yrs.

mos.

ds.

If LESS than  
1 day, hrs.  
OR, min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE

(State or country)

Dorchester Co. Md

## 10 NAME OF FATHER

Amasa Frazier

## 11 BIRTHPLACE OF FATHER

(State or country)

Dorchester Md

## 12 MAIDEN NAME OF MOTHER

Ella Jarrett

## 13 BIRTHPLACE OF MOTHER

(State or country)

Dorchester Md

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Amasa Frazier

(Address)

Cambridge Md

## 15

Filed

Feb 14

1914

E E Waff

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

116

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

July 13

(Month)

(Day)

1914  
(Year)

## 17

I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him alive on 191

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Child still born probably dead  
10 days in uterus from birth.

(Duration) yrs. mos. ds.

## Contributory

Secondary

(Duration) yrs. mos. ds.

(Signed)

K. M. Smith

M. D.

July 4, 1914 (Address) Cambridge Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death

yrs. mos. ds.

In the

State

yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Taylors Island

Feb 14

1914

## 20 UNDERTAKER

M. D.

## ADDRESS

Le Compertay Cambridge

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

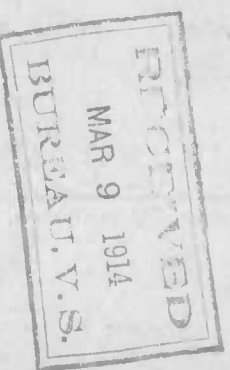
[Approved by U. S. Census and American Public Health Association.]

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*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mecles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mecles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on nomenclature of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| 1 PLACE OF DEATH  |  |   | STATE OF MARYLAND                 |   |  |
|---|--|---|-----------------------------------|---|--|
| County <u>Dorchester</u>  |  |   | CERTIFICATE OF DEATH              |   |  |
| Village or City <u>Church Creek</u>   |  |   | Registration Dist. No. <u>118</u> | [If death occurred in a hospital or institution, give its NAME instead of street and number.] |  |
| 2 FULL NAME <u>James Ferguson</u>   |  |   | St: _____ Ward: _____             |   |  |
| PERSONAL AND STATISTICAL PARTICULARS  |  |   |                                   |   |  |
| 3 SEX<br><u>Male</u>  | 4 COLOR OR RACE<br><u>Col</u>                              | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>single</u> |                                   |   |  |
| 6 DATE OF BIRTH<br><u>July 10, 1892</u><br>(Month) (Day) (Year)   |  |   |                                   |   |  |
| 7 AGE<br><u>23</u> yrs. <u>7</u> mos. <u>7</u> ds. If LESS than 1 day, ____ hrs. OR ____ min. ?   |  |   |                                   |   |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>Laborer</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) <u>Farm</u>  |  |   |                                   |   |  |
| 9 BIRTHPLACE<br>(State or country) <u>Maryland</u>  |  |   |                                   |   |  |
| PARENTS   | 10 NAME OF FATHER <u>Burrister Ferguson</u>                |   |                                   |   |  |
|   | 11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u> |   |                                   |   |  |
|   | 12 MAIDEN NAME OF MOTHER <u>Emma Keene</u>                 |   |                                   |   |  |
|   | 13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u> |   |                                   |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Emma Ferguson</u><br>(Address) <u>Church Creek</u>   |  |   |                                   |   |  |
| 15 Filed <u>Feb 17, 1914</u> <u>John B. Briston</u><br>REGISTRAR  |  |   |                                   |   |  |
| If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.  |  |   |                                   |   |  |
| MEDICAL CERTIFICATE OF DEATH  |  |   |                                   |   |  |
| 16 DATE OF DEATH <u>Feb 17, 1914</u><br>(Month) (Day) (Year)  |  |   |                                   |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,<br>that I last saw him _____ alive on _____, 191____,<br>and that death occurred on the date stated above, at <u>2:30 P.</u> m,<br>The CAUSE OF DEATH* was as follows:<br><u>Laborer</u>              |  |   |                                   |   |  |
| (Duration) _____ yrs. _____ mos. _____ ds.  |  |   |                                   |   |  |
| Contributory (Secondary) _____<br>(Duration) _____ yrs. _____ mos. _____ ds.  |  |   |                                   |   |  |
| (Signed) _____, M. D.<br>_____, 191____ (Address) _____   |  |   |                                   |   |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.   |  |   |                                   |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.<br>Where was disease contracted, If not at place of death? _____<br>Former or usual residence _____ |  |   |                                   |   |  |
| 19 PLACE OF BURIAL OR REMOVAL <u>Madison</u>  |  |   |                                   | DATE OF BURIAL <u>Feb 19, 1914</u>  |  |
| 20 UNDERTAKER <u>Donald Richardson</u>  |  |   |                                   | ADDRESS <u>Church Creek</u>   |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

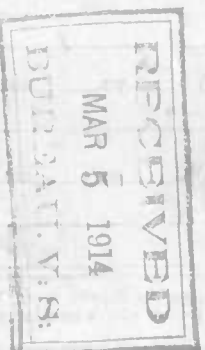
Approved by U. S. Census and American Public Health  
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1 PLACE OF DEATH

1609

County

Dorchester

Village or City

Cambridge (No.

St.

Ward)

Registration Dist. No.

116

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Joshua J. Harris

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

colored

5 SINGLE,  
MARRIED,  
WIDDED,  
ORDIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

Unknown, 1841  
(Month) (Day) (Year)

7 AGE

7 3 yrs. Unknown mos. ds.

If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Gen. Laborer

9 BIRTHPLACE

(State or country)

Md.

PARENTS

10 NAME OF  
FATHER

Unknown

11 BIRTHPLACE  
OF FATHER  
(State or country)

Unknown

12 MAIDEN NAME  
OF MOTHER

Unknown

13 BIRTHPLACE  
OF MOTHER  
(State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Harris

(Address)

Pine St. Cambridge, Md.

15

Filed Feb. 23, 1914

E. E. Wolff

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb. 22, 1914  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

not at all, 191—, to —, 191—,

that I last saw him alive on not recently, 191—,

and that death occurred on the date stated above, at 11:30 p. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage (He was  
Dead when I got there.)  
(Duration) 20 minutes  
yrs. mos. ds.

Contributory

Secondary

Arterio-Sclerosis

(Duration) yrs. mos. ds.

(Signed)

E. E. Wolff

M. D.

Feb. 23, 1914

(Address) Cambridge, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients,  
or Recent Residents)

At place

of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cambridge

Feb. 25, 1914

20 UNDERTAKER

ADDRESS

James &amp; Son City



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

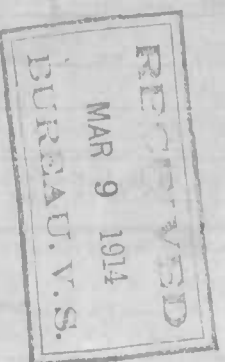
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

1610

County

Dorchester

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 116

Village or City

Cambridge

(No.

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Infant Hughes

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
ORDIVORCED  
(Write the word)

Child

6 DATE OF BIRTH

Jan. 10

(Day)

1914

(Year)

7 AGE

yrs.

mos.

ds.

If LESS than  
1 day,.....hrs.

OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work

None

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Percy Hughes

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Delama Strous

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Percy Hughes

(Address)

Cambridge, Md.

15

Filed

Feb. 3

1914

E. E. Wolfe

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb.

2

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Feb.

2

1914

to

1914

that I last saw him alive on Feb. 2, 1914

and that death occurred on the date stated above, at 11:00 a. m.

The CAUSE OF DEATH\* was as follows:

Inanition

(Duration)

yrs.

mos.

ds.

Contributory  
Secondary

Syphilis

(Duration)

yrs.

mos.

ds.

(Signed)

E. E. Wolfe

M. D.

Feb 3

1914

(Address)

Cambridge, Md.

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16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cambridge, Md.

Feb. 3, 1914

20 UNDERTAKER

ADDRESS

H. H. Miller &amp; Co.

Cambridge, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

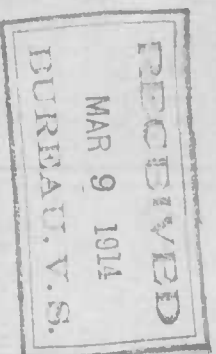
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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|  |   |   |  |
|--|---|---|--|
| 1 PLACE OF DEATH<br>County <u>Dorchester</u> <sup>1611</sup>   |   | STATE OF MARYLAND<br>CERTIFICATE OF DEATH                                     |  |
| Village or City <u>Wingate</u> (No. <u>189</u> )   |   | Registered No. <u>114</u>   |  |
| 2 FULL NAME <u>Levin A. Dusley</u>   |   |   |  |
| PERSONAL AND STATISTICAL PARTICULARS   |   |   |  |
| 3 SEX<br><u>Male</u>   | 4 COLOR OR RACE<br><u>White</u>                                     | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br><u>Widower</u><br>(Write the word) |  |
| 6 DATE OF BIRTH<br><u>January - 6<sup>th</sup></u> , 18 <u>94</u><br>(Month) (Day) (Year)  |   |   |  |
| 7 AGE<br><u>80</u> yrs. <u>1</u> mos. <u>—</u> ds.   |   | If LESS than 1 day, ... hrs. OR ... min. ?                                    |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>Merchant-Camer</u><br>(b) General nature of industry, business, or establishment in which employed (or employer)  |   |   |  |
| 9 BIRTHPLACE (State or country)<br><u>Dorchester County Maryland</u>   |   |   |  |
| PARENTS  | 10 NAME OF FATHER<br><u>Levin Dusley</u>                            |   |  |
|  | 11 BIRTHPLACE OF FATHER (State or country)<br><u>Dorchester Co.</u> |   |  |
|  | 12 MAIDEN NAME OF MOTHER<br><u>Katherine Anderson</u>               |   |  |
|  | 13 BIRTHPLACE OF MOTHER (State or country)<br><u>Dorchester Co.</u> |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>W. Augustin Dusley</u><br>(Address) <u>Cambridge, Md.</u>   |   |   |  |
| 15 Filed <u>Feb 7</u> , 191 <u>4</u> <u>W. J. Curick</u><br>REGISTRAR  |   |   |  |
| MEDICAL CERTIFICATE OF DEATH   |   |   |  |
| 16 DATE OF DEATH <u>Feb</u> <u>6</u> , 191 <u>4</u><br>(Month) (Day) (Year)  |   |   |  |
| 17 I HEREBY CERTIFY. That I attended deceased from <u>Feb 2</u> , 191 <u>4</u> , to <u>Feb 5</u> , 191 <u>4</u> ,<br>that I last saw him alive on <u>Feb 5</u> , 191 <u>4</u> ,<br>and that death occurred on the date stated above, at <u>1 A.</u> m.<br>The CAUSE OF DEATH* was as follows:<br><u>Cardiac Asthenia</u> |   |   |  |
| (Duration) ... yrs. ... mos. <u>7</u> ds.  |   |   |  |
| Contributory (Secondary)<br>(Signed) <u>P. H. Tawes</u> , M. D.<br><u>Feb 7</u> , 191 <u>4</u> . (Address) <u>Wingate, Md.</u>   |   |   |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  |   |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.<br>Where was disease contracted, If not at place of death?<br>Former or usual residence  |   |   |  |
| 19 PLACE OF BURIAL OR REMOVAL<br><u>Wingate</u>  |   | DATE OF BURIAL<br><u>Feb 8</u> , 191 <u>4</u>                                 |  |
| 20 UNDERTAKER<br><u>H. J. Kirwan</u>   |   | ADDRESS<br><u>Crafo</u>   |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

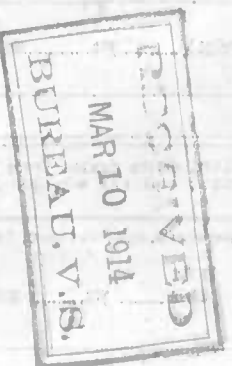
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1612

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 116' PLACE OF DEATH  
County BaltimoreVillage or City Brockton (No. 151)St. Ward[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]2 FULL NAME Mary Melkins

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Caucasian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Jan 14 1914  
(Month) 24 (Day) 1914 (Year)

7 AGE 25 yrs. 25 mos. 25 ds. OR 1 day, 1 hrs. 1 min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Brockton10 NAME OF FATHER William Melkins11 BIRTHPLACE OF FATHER (State or country) md12 MAIDEN NAME OF MOTHER Elizabeth Johnson13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Samuel H. Halsey(Address) Brockton md15 Filed Feb. 9, 1914 EE Wozz

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Feb. 9, 1914  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Not at all, 1914, to Not at all, 1914.that I last saw her alive on Feb. 9, 1914.and that death occurred on the date stated above, at 5-4 m.

The CAUSE OF DEATH\* was as follows:

Inanition.(Duration) 5 yrs. 4 mos. 4 ds.Contributory  
Secondary(Duration) 5 yrs. 4 mos. 4 ds.(Signed) EE Wozz, M. D.  
Feb. 9, 1914 (Address) Cambridge

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 5 yrs. 4 mos. 4 ds. In the State 5 yrs. 4 mos. 4 ds.

Where was disease contracted, if not at place of death?

Former or usual residence Cambridge19 PLACE OF BURIAL OR REMOVAL Brockton md DATE OF BURIAL Feb 10, 191420 UNDERTAKER Lewis H. Bayne ADDRESS Cambridge

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

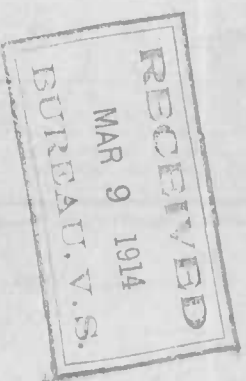
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' PLACE OF DEATH 1613

County

Dorchester

Village or City

Cambridge rd (New)

(No.)

St.; Ward)

Registration Dist. No.

116

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mildred Roberts

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Caucasian

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

May 20

(Month)

(Day)

1913 (Year)

7 AGE

8 yrs. 8 mos. 24 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

9 BIRTHPLACE

(State or country)

Cambridge rd

PARENTS

10 NAME OF FATHER

Charles E. Roberts

11 BIRTHPLACE OF FATHER (State or country)

Cambridge rd

12 MAIDEN NAME OF MOTHER

Mary J. Roberts

13 BIRTHPLACE OF MOTHER (State or country)

Cambridge rd

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mildred Roberts

(Address)

Cambridge rd

15

Filed

Feb. 17

1914

E. E. Wolff

Low

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb 18

1914 (Year)

(Month)

(Day)

17 I HEREBY CERTIFY, That I attended deceased from

not at all, 1914 to 1914

that I last saw him alive on 1914

and that death occurred on the date stated above, at 4 A. m.

The CAUSE OF DEATH\* was as follows:

Measles

(Duration) yrs. mos. ds.

Contributory Secondary

Convulsion

(Duration) yrs. mos. ds.

(Signed)

E. E. Wolff L. R.

M. D.

Feb. 17

1914 (Address)

Cambridge rd

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death yrs. mos. ds.

In the

State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cambridge rd

Feb. 17, 1914

20 UNDERTAKER

ADDRESS

Lewis H. Payne

Cambridge rd

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

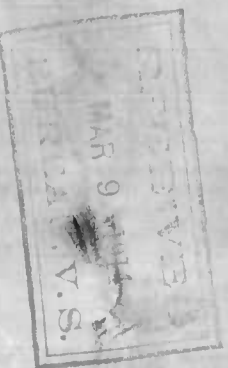
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trigemina," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal peritonitis," etc. State cause, in which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County DorchesterVillage or City Church Creek (No. 10)

## 2 FULL NAME

InfantSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 118

St.; Ward)

[If death occurred to a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Colored5 SINGLE,  
MARRIED, ☒  
WIDDED,  
OR DIVORCED  
(Write the word)

## 6 DATE OF BIRTH

Feb. 9, 1914  
(Month) (Day) (Year)

## 7 AGE

yrs. mos. ds.

If LESS than  
1 day, .... hrs.  
OR .... min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work ☒(b) General nature of industry,  
business, or establishment in  
which employed (or employer) ☒9 BIRTHPLACE  
(State or country)Dorchester Co10 NAME OF  
FATHEREddie Ross11 BIRTHPLACE  
OF FATHER  
(State or country)Dorchester Co.12 MAIDEN NAME  
OF MOTHERStella Cornish13 BIRTHPLACE  
OF MOTHER  
(State or country)Dorchester Co

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Stella Cornish

(Address)

Church Creek, Md

## 15

Filed

Feb 9, 1914John Register

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Feb. 9, 1914  
(Month) (Day) (Year)

## 17

I HEREBY CERTIFY, That I attended deceased from

, 191 to , 191

that I last saw him alive on , 191

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH was as follows:

Sudden

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Victor E. Carroll, M. D.Feb. 9, 1914 (Address) Cambridge, Md\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Church Creek Md Feb 9, 1914

## 20 UNDERTAKER

## ADDRESS

Sam Cornish, father Church Creek



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Trachema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 1615

County DorchesterVillage or City Hopewerille (No. \_\_\_\_\_)

St.; \_\_\_\_\_ Ward \_\_\_\_\_

Registration Dist. No. 115

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Eileen Warner

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Infant  
(Write the word)

6 DATE OF BIRTH November 26th, 1911  
(Month) (Day) (Year)

7 AGE 2 yrs. 2 mos. 18 ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Infant  
(b) General nature of industry, business, or establishment in which employed (or employer) Infant

9 BIRTHPLACE (State or country) Dorchester Co., Ind.

PARENTS 10 NAME OF FATHER Perry Johnson  
11 BIRTHPLACE OF FATHER (State or country) Dorchester Co., Ind.  
12 MAIDEN NAME OF MOTHER Georgianna Warner  
13 BIRTHPLACE OF MOTHER (State or country) Dorchester Co., Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Georgianna Warner(Address) Hopewerille, Ind.

15 Filed Feb. 7th, 1914 W. H. Houston  
Seal REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February 7th, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from January 18th, 1914, to February 7th, 1914, that I last saw her alive on February 5th, 1914

and that death occurred on the date stated above, at 1-30 A.M.

The CAUSE OF DEATH\* was as follows:

Typhoid Fever - meningitis  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 28 ds.

Contributory \_\_\_\_\_  
Secondary \_\_\_\_\_

(Signed) W. H. Houston, M. D.  
Feb. 7th, 1914 (Address) Fishing Creek, Ind.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Hopewerille, Ind. DATE OF BURIAL February 7th, 1914

20 UNDERTAKER Georgianna Warner ADDRESS Hopewerille, Ind.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

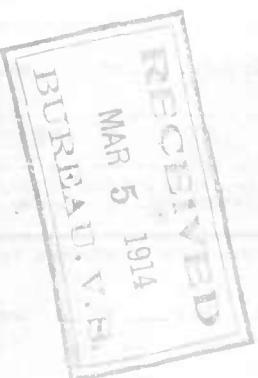
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for violent surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Borchester

Village or City Connersville (No. 80)

2 FULL NAME Joseph Wilson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Negro 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH no information, 1.....  
(Month) (Day) (Year)

7 AGE 04 yrs. .... mos. .... ds. OR It LESS than 1 day, .... hrs. .... min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ind

PARENTS  
10 NAME OF FATHER Joseph Wilson  
11 BIRTHPLACE OF FATHER (State or country) Ind  
12 MAIDEN NAME OF MOTHER Mary Payne  
13 BIRTHPLACE OF MOTHER (State or country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Liddy Wilson

(Address) Connersville

15 Filed Feb 5 1914 S A Stokes  
Local REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 114

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

St.; Ward

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 5, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from Feb 5, 1914, to Feb 5, 1914.

that I last saw him alive on Feb 5, 1914.

and that death occurred on the date stated above, at 1 a m.

The CAUSE OF DEATH\* was as follows:

Heart trouble  
Angina pectoris  
218 (Duration) .... yrs. .... mos. .... ds.

Contributory  
Secondary

(Signed) S A Stokes, M. D.  
Feb 5, 1914 (Address) Connersville

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, It not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Connersville DATE OF BURIAL Feb 6, 1914

20 UNDERTAKER LeCompte & Harper ADDRESS Cambridge

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

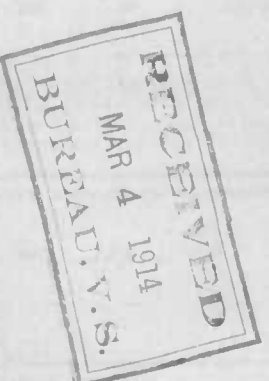
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**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County

Dorchester

Village or City

Airey

(No.

St.

Ward)

## 2 FULL NAME

William H. Windsor

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

## 6 DATE OF BIRTH

April 29<sup>th</sup>, 1860

(Month)

(Day)

(Year)

## 7 AGE

53 yrs. 9 mos. 20 ds.

If LESS than 1 day, hrs. OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE

(State or country)

Maryland

## 10 NAME OF FATHER

James P. Windsor

## 11 BIRTHPLACE OF FATHER

(State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

Annie E. Skeman

## 13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas B. Windsor

(Address)

Airey Md.

## 15

Filed Feb. 18, 1914

E. E. Wagon

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

116

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Feb 17, 1914

(Month)

(Day)

(Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

about Jan. 17, 1914, to Feb 17, 1914.

that I last saw him alive on Feb 17, 1914

and that death occurred on the date stated above, about 3 P. m.

## The CAUSE OF DEATH\* was as follows:

Organic Heart Disease -  
(Myocarditis)

(Duration) yrs. 5 mos. ds.

## Contributory

Secondary

Septic

(Duration) yrs. mos. ds.

(Signed)

D. M. G. L. Long

M. D.

Feb 17, 1914. (Address) Cambridge Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Cambridge Md.

Feb 19<sup>th</sup>, 1914

## 20 UNDERTAKER

## ADDRESS

W. H. Willis &amp; Bro. Cambridge Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

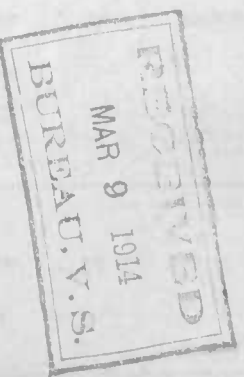
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic catarrhal heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

|  |  |   |  |
|--|--|---|--|
| 1 PLACE OF DEATH<br>County <u>Worcester</u><br>Village or City <u>Hear Williamsburg</u> (No. <u>1618</u> )   |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH<br>Registration Dist. No. <u>110</u><br>St. _____ Ward _____<br>(If death occurred in a hospital or institution, give its NAME instead of street and number.) |  |
| 2 FULL NAME <u>Major Wing</u>  |  |   |  |
| PERSONAL AND STATISTICAL PARTICULARS   |  |   |  |
| 3 SEX<br><u>Male</u>   | 4 COLOR OR RACE<br><u>Black</u>                        | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>Married</u>  |  |
| 6 DATE OF BIRTH<br><u>Jan 10</u> , 191 <u>4</u> , to <u>Feb 4</u> , 191 <u>4</u><br>(Month) (Day) (Year)   |  |   |  |
| 7 AGE<br><u>73</u> yrs. — mos. — ds. OR LESS than 1 day, ... hrs. OR ... min. ?  |  |   |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>Farmer</u><br>(b) General nature of industry, business, or establishment in which employed (or employer)  |  |   |  |
| 9 BIRTHPLACE<br>(State or country) <u>Maryland</u>   |  |   |  |
| PARENTS  | 10 NAME OF FATHER<br><u>Unknown</u>                    |   |  |
|  | 11 BIRTHPLACE OF FATHER<br>(State or country) <u>"</u> |   |  |
|  | 12 MAIDEN NAME OF MOTHER<br><u>"</u>                   |   |  |
|  | 13 BIRTHPLACE OF MOTHER<br>(State or country) <u>"</u> |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Alexander Wing</u><br>(Address) <u>Federalburg, Md. #3-</u>   |  |   |  |
| 15 Filled <u>Feb 4<sup>th</sup></u> , 191 <u>4</u> <u>Robert L. Hastings</u><br>REGISTRAR  |  |   |  |
| MEDICAL CERTIFICATE OF DEATH   |  |   |  |
| 16 DATE OF DEATH <u>Feb 4</u> , 191 <u>4</u><br>(Month) (Day) (Year)   |  |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Jan 10</u> , 191 <u>4</u> , to <u>Feb 4</u> , 191 <u>4</u><br>that I last saw him alive on <u>Feb 2</u> , 191 <u>4</u><br>and that death occurred on the date stated above, at <u>3:30 a. m.</u><br>The CAUSE OF DEATH* was as follows:<br><u>Voluntary heart disease</u><br>(Duration) yrs. <u>15</u> mos. ds.<br>Contributory (Secondary) <u>Calculus of Stomach</u><br>(Duration) yrs. <u>10</u> mos. ds.<br>(Signed) <u>R. G. Frazin</u> , M. D.<br>, 191 <u>4</u> (Address) <u>Hurlock, Md.</u> |  |   |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  |  |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death yrs. mos. ds. In the State yrs. mos. ds.<br>Where was disease contracted, it not at place of death?<br>Former or usual residence.   |  |   |  |
| 19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL<br><u>Hurlock, Md. Feb 5<sup>th</sup></u> , 191 <u>4</u>  |  |   |  |
| 20 UNDERTAKER ADDRESS<br><u>J. S. Brampton, Federalburg, Md.</u>   |  |   |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

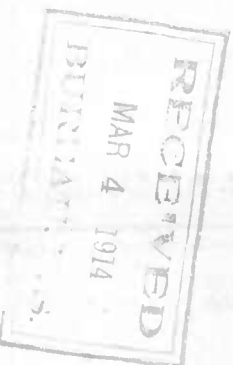
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not rainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1 PLACE OF DEATH<br>County <u>Dorchester</u>  |  | 1619  |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH |  |
| Village or City <u>Vienna R.F.D. (Ruff's Neck)</u>  |  | (No. <u>112</u> )   |  | Registration Dist. No. <u>112</u>         |  |
| 2 FULL NAME<br><u>Wangus</u>  |  | [If death occurred in a hospital or institution, give its NAME instead of street and number.] |  |   |  |
| PERSONAL AND STATISTICAL PARTICULARS  |  |   |  |   |  |
| 3 SEX<br><u>Female</u>  | 4 COLOR OR RACE<br><u>Colored</u>                          | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br><u>Single</u><br>(Write the word)                  |  |   |  |
| 6 DATE OF BIRTH<br><u>March 25, 1913</u><br>(Month) (Day) (Year)  |  |   |  |   |  |
| 7 AGE<br>yrs. <u>10</u> mos. <u>17</u> ds.  |  | If LESS than 1 day,.....hrs. OR.....min. ?  |  |   |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>None</u><br>(b) General nature of industry, business, or establishment in which employed (or employer)   |  |   |  |   |  |
| 9 BIRTHPLACE (State or country) <u>Maryland</u>   |  |   |  |   |  |
| PARENTS   | 10 NAME OF FATHER <u>John Wangus</u>                       |   |  |   |  |
|   | 11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u> |   |  |   |  |
|   | 12 MAIDEN NAME OF MOTHER <u>Lizzie Camper</u>              |   |  |   |  |
|   | 13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u> |   |  |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>John Wangus (Father)</u><br>(Address) <u>Vienna, R.F.D. Md.</u>  |  |   |  |   |  |
| 15<br>Filed <u>Feb 12, 1914</u> <u>Edward E. Lankin</u><br>REGISTRAR  |  |   |  |   |  |
| MEDICAL CERTIFICATE OF DEATH  |  |   |  |   |  |
| 16 DATE OF DEATH <u>Feb. 11<sup>th</sup>, 1914</u><br>(Month) (Day) (Year)  |  |   |  |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____.   |  |   |  |   |  |
| that I last saw h <u>er</u> alive on _____, 191____.  |  |   |  |   |  |
| and that death occurred on the date stated above, at _____ m.   |  |   |  |   |  |
| The CAUSE OF DEATH* was as follows:<br><u>Measles</u><br><u>no doctor in attendance</u><br>(Duration) _____ yrs. _____ mos. _____ ds.   |  |   |  |   |  |
| Contributory Secondary<br><u>Lack of care</u> (Duration) _____ yrs. _____ mos. _____ ds.  |  |   |  |   |  |
| (Signed) <u>Edward E. Lankin</u> , M.D.<br>_____, 191____ (Address) <u>Vienna, R.F.D. Md.</u>   |  |   |  |   |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDE, or HOMICIDE. Bureau V.S. of Md.  |  |   |  |   |  |
| 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)<br>At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.<br>Where was disease contracted, If not at place of death?<br>Former or usual residence _____ |  |   |  |   |  |
| 19 PLACE OF BURIAL OR REMOVAL<br><u>Guffins Neck, Md.</u>   |  |   |  | DATE OF BURIAL<br><u>Feb 12, 1914</u>     |  |
| 20 UNDERTAKER<br><u>Stephen Chase (neighbor)</u>  |  |   |  | ADDRESS<br><u>Vienna R.F.D. Md.</u>       |  |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

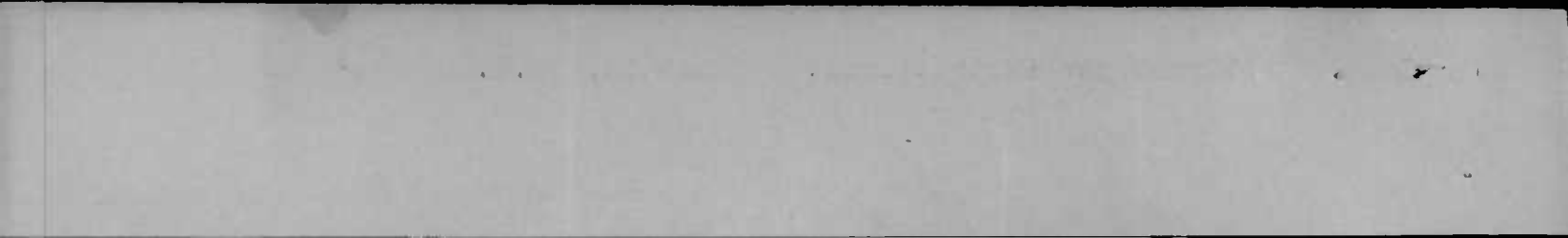
If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAR 3 1914  
BUREAU, V.S.

RECEIVED  
MAY 2 1914  
BUREAU, V.S.

Signed and returned per instructions.

Lamkin, L.R.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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|  |  |   |  |
|--|--|---|--|
| 1 PLACE OF DEATH<br>County <u>Norchester</u> 1620  |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH   |  |
| Village or City <u>Little brick mill</u> (No. <u>28</u> )  |  | Registration Dist. No. <u>112</u>   |  |
| 2 FULL NAME <u>James S. Young</u>  |  | [It death occurred in a hospital or institution, give its NAME instead of street and number.] |  |
| PERSONAL AND STATISTICAL PARTICULARS   |  |   |  |
| 3 SEX<br><u>male</u>   | 4 COLOR OR RACE<br><u>Colored</u>                    | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br><u>married</u><br>(Write the word)                 |  |
| 6 DATE OF BIRTH<br><u>Don't know</u> 1879<br>(Month) (Day) (Year)  |  |   |  |
| 7 AGE<br><u>35</u> yrs. <u>not</u> known mos. <u>not</u> known ds. <u>not</u> known mln. ?   |  | It LESS than 1 day, ..... hrs. OR ..... mln. ?  |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work. <u>Farmer</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) <u>Farming</u>  |  |   |  |
| 9 BIRTHPLACE (State or country) <u>MD</u>  |  |   |  |
| PARENTS  | 10 NAME OF FATHER <u>Joshua Young</u>                |   |  |
|  | 11 BIRTHPLACE OF FATHER (State or country) <u>MD</u> |   |  |
|  | 12 MAIDEN NAME OF MOTHER <u>Maria Lee</u>            |   |  |
|  | 13 BIRTHPLACE OF MOTHER (State or country) <u>MD</u> |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Chas Stanley</u><br>(Address) <u>Little brick mill</u>  |  |   |  |
| 15 FEB 25 1914<br>Filed <u>191</u>   |  | S. S. Landon<br>Deputy Local REGISTRAR.   |  |
| MEDICAL CERTIFICATE OF DEATH   |  |   |  |
| 16 DATE OF DEATH <u>Feb 24</u> , 1914<br>(Month) (Day) (Year)  |  |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Oct. 9</u> , 1913, to <u>Feb. 23</u> , 1914, that I last saw him alive on <u>Feb. 23</u> , 1914, and that death occurred on the date stated above, at <u>12.15</u> a.m., The CAUSE OF DEATH* was as follows:<br><u>Tuberculosis of Lungs</u> |  |   |  |
| (Duration) 0 yrs. 5 mos. 0 ds.   |  |   |  |
| Contributory Secondary (Duration) ..... yrs. .... mos. .... ds.  |  |   |  |
| (Signed) <u>H. F. Nicols</u> , M. D.<br><u>2/24</u> , 1914. (Address) <u>E. N. market md.</u>  |  |   |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  |  |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.<br>Where was disease contracted, If not at place of death? .....<br>Former or usual residence. ....            |  |   |  |
| 19 PLACE OF BURIAL OR REMOVAL<br><u>Salem, Maryland.</u>   |  | DATE OF BURIAL<br><u>2/26</u> , 1914  |  |
| 20 UNDERTAKER<br><u>H. H. Wiloughby</u>  |  | ADDRESS<br><u>E. N. market md.</u>  |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

